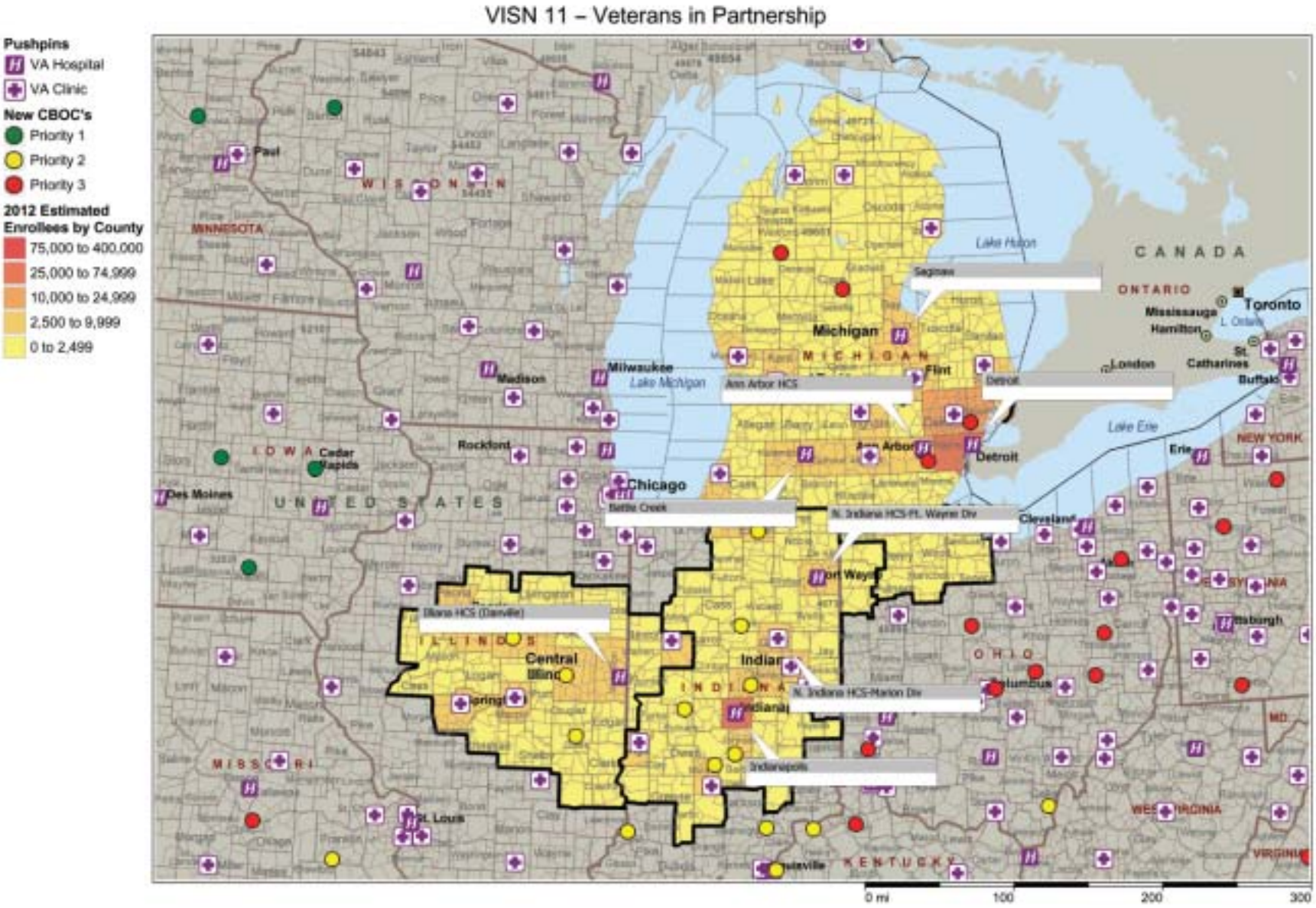

VISN 11, Veterans in Partnership

VISN Overview

VISN 11, Veterans in Partnership, is an integrated, comprehensive health care system that provided medical services to approximately 189,000 of the 298,000 veterans enrolled in VA's health care system in FY 2003.[280] Geographically, this VISN spans about 90,100 square miles in Lower Michigan, Indiana, and Central Illinois, and includes a total veteran population of 1.4 million.[281] With a VA staff of approximately 8,066 FTEs,[282] VISN 11 delivers health care services through eight medical centers, 21 community-based outpatient clinics (CBOCs), and six nursing homes. In addition, VA operates six Vet Centers in VISN 11.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 11.

VISN 11	FY 2001	FY 2012	FY 2022
Enrollees	249,012	275,868	248,315
Veteran Population	1,485,477	1,147,624	915,903
Market Penetration	16.76%	24.04%	27.11%

For the CARES process, this VISN is divided into three markets: Michigan Market (*facilities:* Ann Arbor, Detroit, Battle Creek, and Saginaw); Indiana Market (*facilities:* Fort Wayne, Marion, and Indianapolis); and Central Illinois Market (*facility:* Illiana).

Information Gathering

The CARES Commission visited two sites and conducted two public hearings in VISN 11. The Commission received 2,238 comments regarding VISN 11.

- *Site Visits:* Fort Wayne and Marion, IN, on July 14.
- *Hearings:* Fort Wayne, IN, August 20; Detroit, MI, August 22.

[280] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[281] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender,* as of the end of FY 2003.
[282] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Summary of CARES Commission Recommendations

I Small Facility – Fort Wayne Campus of the Northern Indiana Health Care System (HCS)

1. The Commission concurs with the DNCP proposal to close acute care at Fort Wayne and transfer these services to other VA facilities or contract in the local community.
2. The Commission recommends that:
   a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission concurs with the DNCP proposal to maintain outpatient care at Fort Wayne.

(see page 5-203)

II Small Facility – Saginaw VA Medical Center (VAMC)

1. The Commission concurs with the DNCP proposal to discontinue acute medical services at Saginaw, but does not concur with adding beds at the Ann Arbor VAMC to accommodate additional workload from Saginaw (see Inpatient Care).
2. The Commission recommends that:
   a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission concurs with the DNCP proposal to maintain nursing home and outpatient care at Saginaw.

(see page 5-205)

III Inpatient Care

1. The Commission does not concur with the DNCP proposal to add additional beds at Ann Arbor to accommodate additional workload from Saginaw.

2 The Commission recommends that the inpatient workload projections be validated. If validated, the Commission supports the DNCP proposal for construction of beds at Ann Arbor and opening the unused unit at Detroit.

(see page 5-208)

IV Improve Access to Hospital Care in Central Illinois

1 The Commission concurs with the DNCP proposal to contract with hospitals in Central Illinois for inpatient care.

2 The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-209)

V Outpatient Care

1 The Commission concurs with the DNCP proposal for outpatient care.

2 The Commission recommends that: [283]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

[283] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCS as teaching sites to enhance quality of care in community-based service settings.

(see page 5-211)

VI Proximity of Ann Arbor and Detroit VAMC Services

1 The Commission concurs with the DNCP proposal to maintain tertiary facilities in Michigan at both Ann Arbor and Detroit, with continued consolidation of services.

2 The Commission recommends shifting appropriate Post-Traumatic Stress Disorder (PTSD) and substance abuse services from Battle Creek to Detroit.

(see page 5-213)

VII Pursue Enhanced Use Leasing for Danville and Battle Creek Excess Space

1 With respect to the proposed enhanced use lease at the Illiana VAMC for a replacement nursing home, the Commission recommends that: [284]

a Prior to taking any action to reconfigure or expand long-term care (LTC) capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

2 The Commission concurs with pursuing enhanced use leasing (EUL) opportunities at the Battle Creek VAMC.

(see page 5-215)

[284] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.

Small Facility – Fort Wayne Campus of the Northern Indiana HCS

DNCP Proposal

"The Fort Wayne VAMC, a division of the Northern Indiana Health Care System, will maintain outpatient services. Acute medicine services will be transferred to Indianapolis, together with partial contracting out for inpatient/emergent care services. Patient transfer protocols will be upgraded to address these significant changes. The Indianapolis VAMC does not require renovation prior to the consolidation."

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The Fort Wayne facility, part of the Northern Indiana Health Care System, currently operates 26 inpatient medicine beds (with an average daily census [ADC] of 22).[285] The Marion campus has inpatient psychiatry beds and nursing home care beds.

At the Fort Wayne hearing, Ms. Linda Belton, the VISN Director, described the rationale for the proposed closure of the inpatient capacity at Fort Wayne, noting:

> The Fort Wayne campus of Northern Indiana anticipates a Fiscal Year 2012 average daily census of 11 in acute medicine, with an average daily census of 10 in FY 2022. VISN 11 proposes to close the remaining 26 acute medical beds, increase contract hospitalization, and continue to transfer appropriate patients to Indianapolis.[286]

[285] Appendix D, *Data Tables*, page D-56.
[286] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 20.

When asked about VA's ability to contract for care in the Fort Wayne community and about the quality of care in the community, Dr. Michael Murphy, the Director of VA's Northern Indiana Health Care System, noted that "Fort Wayne is a rather substantial medical community with two tertiary facilities – Parkview and Lutheran – and those hospitals are generally within the top 100 hospitals in the country in their category."[287] The Commission notes that these two facilities are among the nine JCAHO-accredited community hospitals within 60 minutes of Fort Wayne, which all appear to have the ability to contract with VA for needed services for veterans.[288]

In response to a question about the economic implications of the DNCP proposal to move acute medicine services and contract out inpatient and emergent care, Mr. Craig Anderson, VISN 11 CARES Coordinator, testified:

> There are some savings that are being projected with this move. We should not forget about the cost being provided by Indianapolis, and we've also calculated those costs. But the savings that are being projected for the closure of beds at Fort Wayne, which will assist us in expanding other programs, is approximately 2.1 million dollars per annum.[289]

With respect to the impact on employees now at Fort Wayne, Ms. Belton indicated that there were 29.4 FTEs associated with the inpatient program and that these employees would be reassigned or retrained.[290] Ms. Belton added that the VISN "has made a commitment not to use reductions in force, except as a last resort" and that, "in eight years, we have not had to resort to that."[291] There was, however, no guarantee that all who might lose their jobs will be reemployed.

There was strong opposition from veterans service organizations (VSOs) and employee organizations to the proposed closure of acute medicine at the Fort Wayne facility.

Commission Findings

1 There are nine JCAHO-accredited community hospitals within 60 minutes of Fort Wayne.

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[287] Michael W. Murphy, PhD, Director, Northern Indiana Health Care System, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 26.
[288] Appendix D, *Data Tables*, page D-57.
[289] Craig Anderson, VISN 11 CARES Coordinator, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 32.
[290] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 32.
[291] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 33.

2. The VISN projects savings of approximately $2.1 million with the closure of beds at Fort Wayne.
3. The VISN testified that, based on available data, the major health care providers in Fort Wayne, identified in VISN testimony, along with the Indianapolis VAMC, could absorb Fort Wayne's workload.
4. Fort Wayne's ADC is projected to decline from the current ADC of 20 to 11 by FY 2012 and to 10 by FY 2022.[292]

Commission Recommendations

1. The Commission concurs with the DNCP proposal to close acute care at Fort Wayne and transfer these services to other VA facilities or contract in the local community.
2. The Commission recommends that:
   a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
   b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.
3. The Commission concurs with the DNCP proposal to maintain outpatient care at Fort Wayne.

II Small Facility – Saginaw VAMC

DNCP Proposal

"Saginaw VAMC will maintain outpatient and nursing home services. Acute medicine services will be transferred to Ann Arbor and Detroit. There will be partial contracting out for inpatient/emergent care services and to improve the access for patients in the northern sectors of Lower Michigan. Patient transfer protocols will be upgraded to address these significant changes, and the Ann Arbor HCS must be upgraded prior to any bed consolidation to address the transfer of projected medicine patients to this facility. The Detroit VAMC does not require renovation prior to the consolidation."

[292] Appendix D, *Data Tables*, page D-56.

DNCP Alternatives

1. Retain acute hospital beds.
2. Close acute hospital beds and reallocate workload to another VA facility.
3. Close acute hospital beds and implement contracting, sharing, or joint venturing for workload in the community.
4. Combination of any of the above, but predominately contracting with a community provider(s) and referral to another VAMC(s).

Commission Analysis

The Saginaw VAMC currently operates 27 medicine beds (ADC 11), six intermediate beds (ADC 5), and 81 nursing home care beds (ADC 67). The Saginaw VAMC is located approximately 100 miles from the Ann Arbor and Detroit VAMCs.

At the Detroit hearing, Ms. Belton, addressing the plans for the Saginaw VAMC, testified as follows:

> The Saginaw campus anticipates an FY 2012 average daily census [ADC] of 18 in acute medicine with an ADC of 17 by FY 2022. To meet the small facility standards, VISN 11 proposes to close acute beds at this facility, to maintain 6 to 8 intermediate observation, transition-type beds, to increase contract hospitalization in Saginaw and the northern part of lower Michigan; for example, Traverse City, Charlevoix, Cheboygan, and Presque Isle and to also transfer some acute bed capacity to both Ann Arbor and Detroit. We believe that these actions will improve the access and quality of care.[293]

At the same hearing, the Saginaw VAMC Director, Mr. Gabriel Perez, in response to a question as to how VA would meet the needs of veterans now served by the Saginaw facility, testified:

> That's part of our plan as well, especially depending on the emergent nature and the medical status of the patient, to have them be treated at one of those facilities within our community. And even more, to set up contracts with our northern tier areas, Traverse City, Gaylord, Oscoda areas. So that way, the veteran will have better access than what they have right now.[294]

[293] Linda Belton, VISN 11 Director, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 14.
[294] Gabriel Perez, Director, Saginaw VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 26.

In describing the community health care facilities in Saginaw with which VA might contract for care, Mr. Perez noted that there are "two very strong tertiary care facilities that are competitive, Covenant Health Care System and St. Mary's Health Care System."[295] Mr. Perez added, "They both have level 1 emergency rooms, open heart surgery in both. So, they can handle anything in the community."[296] The Commission notes that there are 11 JCAHO accredited community hospitals within 60 minutes of Saginaw and that there appears to be sufficient capacity in the community to provide services to those veterans who could not be referred to either the Ann Arbor or Detroit medical centers.[297]

With regard to the potential impact on employees at the Saginaw facility from the proposed mission change, Mr. Perez noted that the increasing workload in the outpatient care area would result in jobs for all employees, adding, "Some people may not have the same positions they had before, like on the ward. They have to shift to the outpatient area."[298]

Commission Findings

1. The Ann Arbor and Detroit VAMCs are approximately 100 miles from Saginaw.
2. There are 11 JCAHO accredited community hospitals within 60 minutes of Saginaw, which appear to have excess capacity and could provide services through contracting.
3. Saginaw's ADC for acute care is projected to increase to 21 by FY 2012 and then to decline to 16 by FY 2022.[299]

Commission Recommendations

1. The Commission concurs with the DNCP proposal to discontinue acute medical services at Saginaw, but does not concur with adding beds at the Ann Arbor VAMC to accommodate additional workload from Saginaw (see Inpatient Care).
2. The Commission recommends that:
    a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

[295] Gabriel Perez, Director, Saginaw VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 25.
[296] Gabriel Perez, Director, Saginaw VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 25.
[297] Appendix D, *Data Tables*, page D-54.
[298] Gabriel Perez, Director, Saginaw VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 39.
[299] Appendix D, *Data Tables*, page D-54.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

3 The Commission concurs with the DNCP proposal to maintain nursing home and outpatient care at Saginaw.

III Inpatient Care

DNCP Proposal

"Increase inpatient medicine beds in the Michigan market to meet the projected demand. The Ann Arbor HCS and the Detroit VAMC will need to increase their compliment of medicine beds to meet that projected demand and to add additional beds to meet the change in acute beds from Saginaw (small facility) and the consolidation of five beds from the Battle Creek VAMC."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

In addition to the impact of the proposed closure of the Saginaw VAMC and of the closing of acute medicine beds at the Battle Creek VAMC, the CARES process projected an increased demand for medicine beds in the Michigan Market, with an additional 84 beds over the FY 2001 baseline needed by FY 2012, decreasing to 40 beds over baseline by FY 2022.[300] To meet this increased demand, the VISN proposed adding, by FY 2012, 43 beds at the Ann Arbor HCS and 32 beds at the Detroit VAMC. The increase in demand for medicine beds is based on a projected increase in market penetration. At present, the VISN's market penetrations of 14 percent is one of the lowest in the VA system; the CARES model projects an increase to a 25 percent market penetration.

At the Detroit hearing, Ms. Linda Belton, the VISN Director, testified that the projected increase is based on "seeing an increase in market share over the last couple of years as there are changes in the local industries, layoffs, some decrease in benefits…"[301] She noted that the increased demand could be met at

[300] Appendix D, *Data Tables*, page D-53.

[301] Linda Belton, VISN 11 Director, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 38.

Ann Arbor by converting "vacated space through minor construction" and at Detroit by activating "an existing unutilized nursing unit."[302] The Director of the Detroit VAMC said that the unutilized nursing unit is on the 7th floor of the bed tower at Detroit and is space that has not been used since the facility was opened.[303]

Commission Findings

1. There is an increase in demand projected for inpatient medicine beds in the Michigan market based on a significant increase in the VISN's market penetration. It is not clear that this increase will occur.
2. There is significant vacant space at the Detroit VAMC.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to add additional beds at Ann Arbor to accommodate additional workload from Saginaw.
2. The Commission recommends that the inpatient workload projections be validated. If validated, the Commission supports the DNCP proposal for construction of beds at Ann Arbor and opening the unused unit at Detroit.

IV Improve Access to Hospital Care in Central Illinois

DNCP Proposal

"Increase access for hospital care in the Central Illinois Market by contracting with community providers at two new sites on the western side of the market."

DNCP Alternatives

None provided in the DNCP.

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[302] Linda Belton, VISN 11 Director, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 15.

[303] Michael Wheeler, Director, Detroit VAMC, Transcribed Testimony from the Detroit, MI, Hearing on August 22, 2003, page 47.

Commission Analysis

Only 36 percent of Central Illinois veterans live within 60 minutes of a VA hospital. Since the nearest VA facility is the Illiana VAMC in Danville, veterans on the west side of the market fall outside the CARES guidelines for access to hospital care (the standard is 65 percent).[304] The Commission notes that there is a significant demand for services in this part of the state as the two existing CBOCs, one in Peoria and one in Springfield, furnished services to more than 10,000 individual veterans in FY 2003.[305]

To address this gap in access to hospital care, the VISN proposes to contract for care in the western side of the Central Illinois Market. As Ms. Linda Belton, VISN Director, testified:

> With the Danville Medical Center located at the far eastern end of the [Central Illinois] market, veterans in Peoria and Springfield have to travel two hours for hospital care. So to meet the CARES access standard, VISN 11 will contract with community providers in those areas for inpatient medical and surgical care. This action will bring access to hospital care from 36 percent to 85 percent.[306]

Dr. William P. Marshall, the Chief of Medicine at the Illiana VAMC, testified at the Fort Wayne hearing on behalf of the College of Medicine at the University of Illinois where he holds a faculty appointment as the Chairman of Internal Medicine. Addressing the proposed contracting for hospital care in the western side of the market, Dr. Marshall noted that this change "would negatively impact to a certain degree" on the number of admissions to the Illiana VAMC, but that the "critical number of patients" needed by Illiana to attract staff would be maintained.[307]

Commission Findings

1. Contracting with the community hospitals in Peoria and Springfield will improve access to hospital care to 85 percent of the veterans in the Central Illinois Market.
2. Contracting for hospital care in the western portion of the market may have an impact on the demand for care at the Illiana VAMC; however, that impact is not anticipated to affect the ability to attract staff at the Illiana VAMC.

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[304] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 18.
[305] Craig Anderson, VISN 11 CARES Coordinator, Email to William E. Brew, January 13, 2004.
[306] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 18.
[307] William P. Marshall, MD, Chief of Medicine, Danville VAMC / Chairman, Internal Medicine, College of Medicine of the University of Illinois, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 101.

Commission Recommendations

1 The Commission concurs with the DNCP proposal to contract with hospitals in Central Illinois for inpatient care.

2 The Commission recommends that:

- a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
- b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

V Outpatient Care

DNCP Proposals

"*Primary Care* – Increase primary care in two markets and at all care sites except the Illiana HCS at Danville, IL. *Specialty* Care – Increase the specialty outpatient care in all three markets and at all eight cares sites to include selected CBOCs. Three innovative telemedicine networking systems located at the tertiary level facilities are also proposed. These new systems can provide care and consultation services to the veteran in either another VHA facility or at his/her home. These systems will particularly assist the older veteran with ambulation issues, dementia, Alzheimer's, Parkinson's, and the SCI patient. These systems have shown that they can increase patient satisfaction and significantly reduce the number of emergency room, and other visits, and future hospitalizations."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

Currently, two markets fall below the CARES 70 percent standard for providing access to primary care within 30 minutes of veterans' homes: Central Illinois (54 percent) and Indiana (63 percent).[308] The CARES model projects that, by FY 2012, primary care workload will increase significantly, by

[308] VISN 11 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=53*].

58 percent over the FY 2001 baseline in Indiana and by 76 percent over baseline in Michigan. Likewise, there is a projected increase by FY 2012 in demand for specialty care, with the workload in Central Illinois projected to increase by 139 percent over baseline, in Indiana by 60 percent over baseline, and in Michigan by 154 percent over baseline.[309] The VISN plans to expand existing sites of care through conversion or renovation of existing space or leasing additional space. There are also plans to increase the use of telemedicine and to contract for care.[310]

During the Fort Wayne site visit, Commissioners learned two Northern Indiana CBOCs are closed to new enrollment. They were also told that Fort Wayne wants to submit a proposal to the VISN 11 Clinical Leadership Board to add specialty care in selected CBOCs, such as the South Bend and Muncie clinics.[311]

As part of its CARES submission, VISN 11 proposed adding 14 new CBOCs by FY 2006.[312] Although 10 of the proposed CBOCs are in the two markets with access gaps – Central Illinois and Indiana – none is in the DNCP priority group one. As Congressman Evans noted about proposed CBOCs in Central Illinois, "…omitting these clinics means that the VISN continues to fail to meet its national access standard for almost half (46 percent) of the [Central Market] enrolled veterans, relegating veterans… to a much lower standard of access than most of the nation's veterans enjoy. "[313]

Commission Findings

1. The establishment of three CBOCs in Lower Michigan and two in Northern Indiana will enhance services in areas that will be impacted by the proposed closure of inpatient services at the Saginaw and Fort Wayne VAMCs.
2. The establishment of three new CBOCs in Illinois and five additional new CBOCs in Indiana will address deficiencies in meeting access standards.
3. It is not clear that merely expanding existing CBOCs will adequately address access gaps.

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[309] Appendix D, *Data Tables*, page D-53.

[310] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 6.

[311] VISN 11, Site Visits Marion/ Fort Wayne on July 14, 2003, page 3, available from [*http://www.carescommission.va.gov/Documents/SiteVisitVISN11MarionFortWayne.pdf*].

[312] National CARES Planning Office (NCPO), Department of Veterans Affairs, CBOC Analysis, provided to the Commission on December 11, 2003.

[313] The Honorable Lane Evans, Congressman from Illinois, Written Testimony submitted at Wayne, IN, Hearing on August 20, 2003, pages 1-2, available from [*http://www.carescommission.va.gov/Documents/FortWayneCongressionalStatements.pdf*].

Commission Recommendations

1. The Commission concurs with the DNCP proposal for outpatient care.
2. The Commission recommends that:[314]
   - a. The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
   - b. VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
   - c. VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
   - d. VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
   - e. Whenever feasible, CBOCs provide basic mental health services.
   - f. VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCS as teaching sites to enhance quality of care in community-based service settings.

VI Proximity of Ann Arbor and Detroit VAMC Services

DNCP Proposal

"The Ann Arbor and Detroit facilities currently have several services that they have consolidated and they include: cardiac, surgery, neurosurgery, interventional cardiology, cochlear implant, gynecologic cytopathology, nuclear medicine, sleep laboratory, GRECC, HSR&D, contract administration, prosthetic management. Future consolidations to be considered are: home oxygen management and radiology interpretation."

DNCP Alternatives

None provided in the DNCP.

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[314] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

Commission Analysis

Ann Arbor and Detroit are 46 miles apart, and are affiliated with the University of Michigan (UMHS) and Wayne State, respectively. Internal medicine occupancy in FY 2002 was 90 percent at Ann Arbor and 72 percent at Detroit. Combined surgery admissions were 36 patients a day, with two-thirds of these patients at Ann Arbor.[315] Projected inpatient workload peaks by FY 2008, gradually declining through FY 2022.[316] As discussed earlier, both facilities will absorb some workload if the DNCP proposal to close inpatient care at the Saginaw VAMC is implemented.

Commissioners reviewed a patient Zip code analysis that showed different referral patterns at each facility. Detroit serves its local community, with 80 percent of the patients from two counties. Ann Arbor is a statewide referral center, with 80 percent of the patients from 17 counties.[317] In recent years, VISN 11 has consolidated high-tech, high-cost care at Ann Arbor, including open-heart surgery and neurosurgery.

The post-traumatic stress disorder (PTSD) residential program is located in Battle Creek, 125 miles from Detroit. As Mr. Bob Rasche from The American Legion testified, "Veterans from the Detroit area needing post traumatic stress disorder (PTSD) treatment and therapy for some other mental health needs would be disadvantaged by having to travel to Battle Creek."[318] As noted in the analysis of Inpatient Care (above), there is significant unused and underutilized space at the new Detroit VAMC. The Commission has consistently based its decisions on the principle that residential rehabilitation services should be placed as close to the populations they serve as feasible. The availability of space at Detroit raises the question of why veterans with PTSD, a high priority for VA, need to travel great distances and because of these distances, have it more difficult for their family to be involved in treatment, when VA has already invested in providing clinical space in downtown Detroit that is underutilized.

Commission Findings

1. A significant VA presence is needed in both Detroit and Ann Arbor; neither facility could absorb the total services from the other facility.

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[315] VSSC KLF Menu Database, *Occupancy Rates Report,* October 2001 through September 2002.

[316] VISN 11 CARES Planning Initiatives, *Power Point slide show*, available from [*http://www1.va.gov/cares/page.cfm?pg=53*].

[317] CARES Portal, VISN 11, Michigan Market County-Facility Workload Allocation Workbook.

[318] Bob Rasche, Department Service Officer, The American Legion, Written Testimony submitted at the Detroit, MI, Hearing on August 22, 2003, page 4, available from [*http://www.carescommission.va.gov/Documents/DetroitPanel2PART1.pdf*].

2 Residential rehabilitation services should be provided close to the hometown of the majority of the patients in such programs.

Commission Recommendations

1 The Commission concurs with the DNCP proposal to maintain tertiary facilities in Michigan at both the Ann Arbor and Detroit, with continued consolidation of services.

2 The Commission recommends shifting appropriate PTSD and substance abuse services from Battle Creek to Detroit.

VII Pursue Enhanced Use Leasing for Danville and Battle Creek Excess Space

DNCP Proposal

"There are several enhanced use lease projects planned by the Network to address significant space issues to meet the projected primary and specialty outpatient care workload. There are significant enhanced use projects planned at the Battle Creek (new mental health building and Vet Center), the Illiana HCS for the new nursing home care unit, and at NIHCS – Fort Wayne Division to relocate their outpatient services and dispose of their inpatient building to a community provider."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

VISN 11 has a successful EUL at the former Cold Spring Road facility of the Indianapolis VAMC, generating a trust fund for innovative VISN 11 programs. In FY 2002, $1.9 million from the fund was designated for telehealth programs, an important VISN 11 initiative.[319]

Currently, most VISN vacant space is in Danville (at the Illiana VAMC), Marion, and Battle Creek; VISN 11 is actively consolidating services at all campuses to reduce overhead costs.

[319] Craig Anderson, VISN 11 CARES Coordinator, as reported in the July 14, 2003 Fort Wayne Site Visit, page 3, available from [*http://www.carescommission.va.gov/Documents/SiteVisitVISN11MarionFortWayne.pdf*].

Three vacant buildings at the Illiana VAMC were converted to senior housing through enhanced lease agreements. There are longstanding issues relating to the environment for care at the 280-bed Illiana VAMC nursing home, which is housed in a 40-year-old building. It does not meet standards under the Americans with Disabilities Act or VA patient privacy standards and has space and functional issues.[320]

For Battle Creek, the DNCP describes using the EUL process for a new mental health building and a Vet Center. During the Detroit hearing, Ms. Alice Wood, Director of the Battle Creek VAMC, provided more detail about these proposals. With respect to the mental health building, Ms. Wood indicated that "the simplest and the cleanest [arrangement] would be to simply build the mental health facility that we need with an outside developer coming in, building it for us and then leasing it to us." With respect to the other proposed EUL prospect, Ms. Wood clarified that the proposal was for a "Vet Village" which would be a "privately-owned and operated assisted living" facility on the grounds of the medical center that would be available to veterans.

At the Fort Wayne hearing, the VISN Director noted that some unused buildings on the Marion Campus were proposed for demolition and that other vacant space will be converted to provide ambulatory care. She also discussed the possibility of ceding nine acres of land at Marion to NCA for use as a cemetery.

Commission Findings

1. The existing nursing home at the Illiana VAMC does not meet standards under the ADA, does not meet VA patient privacy standards, and has space and functional issues.
2. In light of the VISN's experience with the EUL process, the DNCP proposal to use the process for a new mental health building and 'Vet Village' in Battle Creek may be achievable, though it is not clear there are developers interested in these projects.

[320] Linda Belton, VISN 11 Director, Transcribed Testimony from the Fort Wayne, IN, Hearing on August 20, 2003, page 18.

Commission Recommendations

1. With respect to the proposed enhanced use lease at the Illiana VAMC for a replacement nursing home, the Commission recommends that: [321]
   a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
   b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   c. Domiciliary care programs should be located as close as feasible to the population they serve.
   d. Freestanding LTC facilities should be permitted as an acceptable care model.
2. The Commission concurs with the DNCP proposal to pursue EUL opportunities at the Battle Creek VAMC.

[321] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.